### Changing Practice/Changing Lives

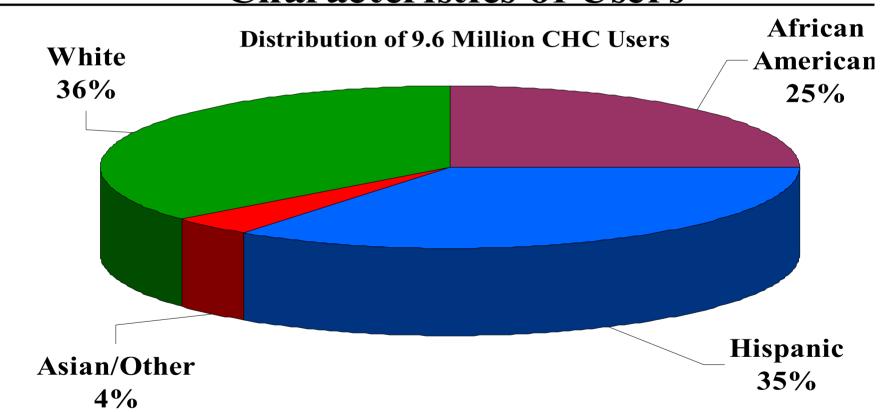
# Update on Diabetes Prevention & Treatment

DMICC
March 11, 2002
David M. Stevens, MD
HRSA/BPHC

## Health Centers

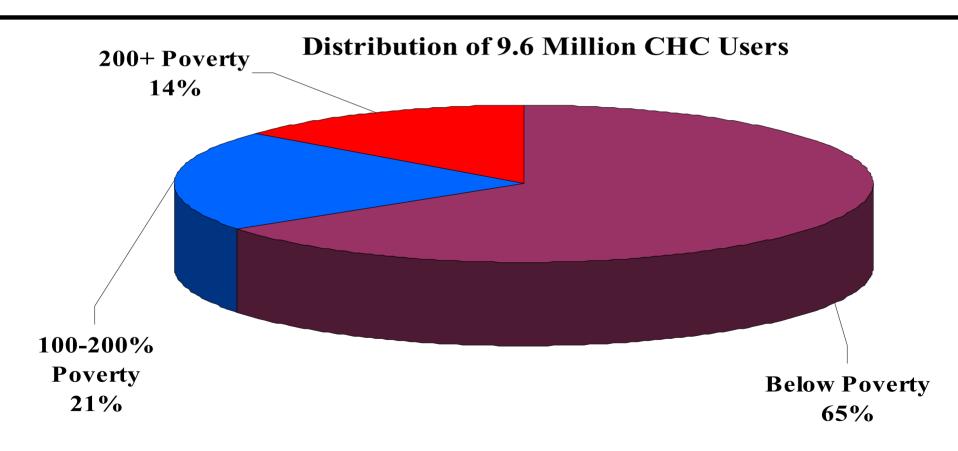
- Community controlled
- Comprehensive Primary Care
- 768 organizations
- 3,552 sites: rural & urban

# UDS Answers Priority Questions: Number and Sociodemographic Characteristics of Users



Source: Uniform Data System (UDS) Contact:NCAMPBELL@SHRS.GOV

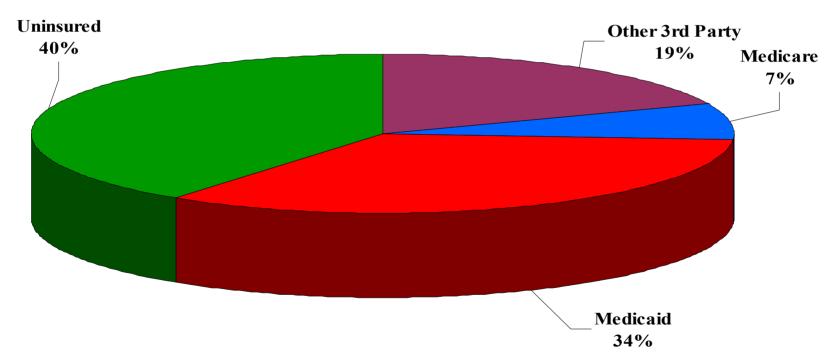
## 86% Of Those Served by Health Centers Are Low Income



Source: Uniform Data System (UDS) Contact:NCAMPBELL@SHRS.GOV

## 40% Of Those Served by Health Centers Are Uninsured

#### **Distribution of 9.6 Million CHC Users**



Source: Uniform Data System (UDS) Contact:NCAMPBELL@SHRS.GOV

## **BPHC Strategic Goal and Objectives**

Moving Toward 100% Access/Eliminating health disparities

Workforce to Meet the Need

Strengthening the Safety Net

New Access
through
Community
Development
Expansion and
Partnerships

Excellence in **Practice** 

### **Excellence in Practice: Strategy**

- Leadership
- Transform clinical practice through models of care, improvement & learning
- Infrastructure/Support System
- Strategic Partnerships

# Transform practice: Models

- Chronic Care Model: a population based model that relies on knowing which patients need the care, assuring that they receive knowledge-based care and actively aiding them to participate in their own care
- <u>Improvement Model</u>: A model that reaches high levels of performance by applying knowledge through rapid testing, transforms the care by changing systems, and expands the change throughout the practice.
- Learning Model: A performance-based learning method that supports a community of learners to apply, adapt, share, and generate knowledge, and spread positive change.

#### The Health System Organization of Health Care **Community** \*Strategic plan \*Senior leaders\*Benefits\*Provider incentives Resources and Policies Practice Level Effective programs **Clinical Self-Mgt Support Delivery Partnerships** Decision Coordination **Information System** • Emphasis on patient role support **Design Systems** Standardized assessment Evidence • Effective interventions based • Team roles and •Registry guidelines tasks • Care planning and problem •Care reminders solving Specialist Planned visits Individual care expertise planning Continuity Provider •Relevant subgroups • Regular follow-up education Guidelines Informed, Prepared, for patients

Activated
Patient

Productive Interactions:

Prepared,
Proactive
Practice Team

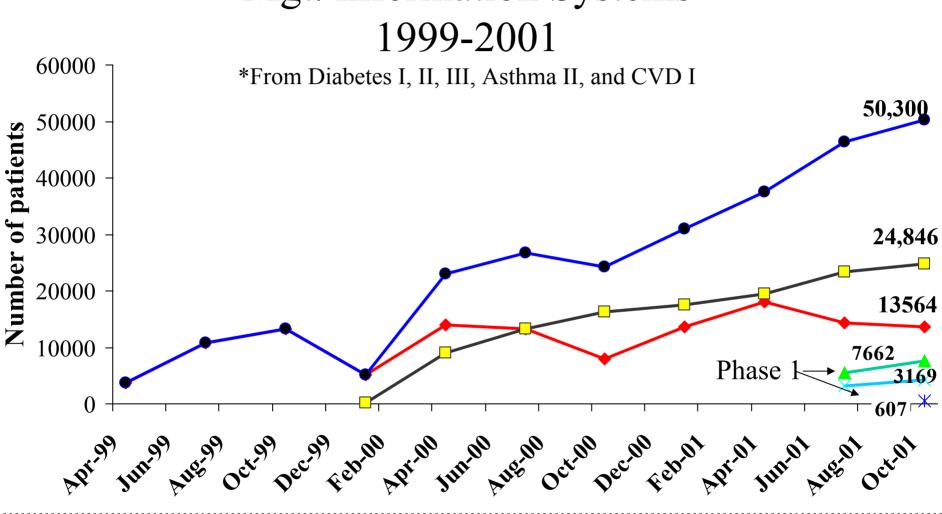
### **Improved Functional and Clinical Outcomes**

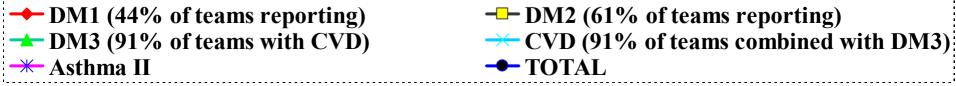
ICIC, Robert Wood Johnson Foundation at the McCall Institute for Healthcare Innovation, Group Health Cooperative of Puget Sound

### Diabetes Collaborative Measures

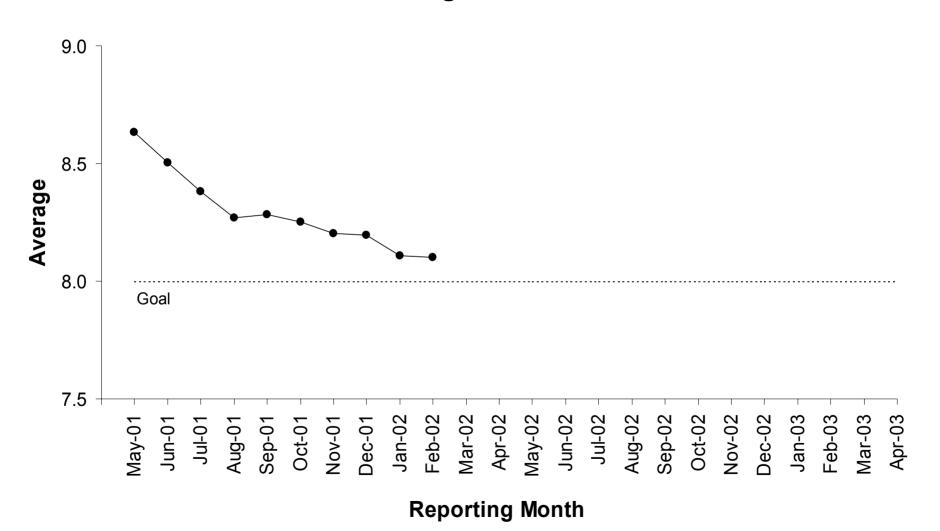
- \*Documented Patient self-management goal
- \*Glycemic control
- Prevention of cardiac complications
- Prevention of vascular complications
- Immunization
- Oral Health
- Depression screening
- \*Registry size & practice sites(270 health centers focused on diabetes)

## Number of Health Center Patients\* in Clinical Mgt. Information Systems

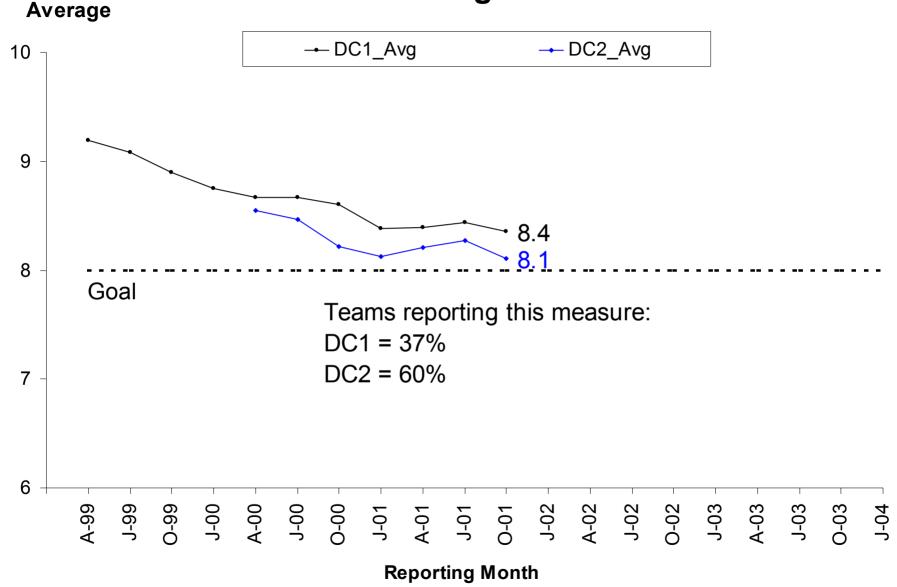


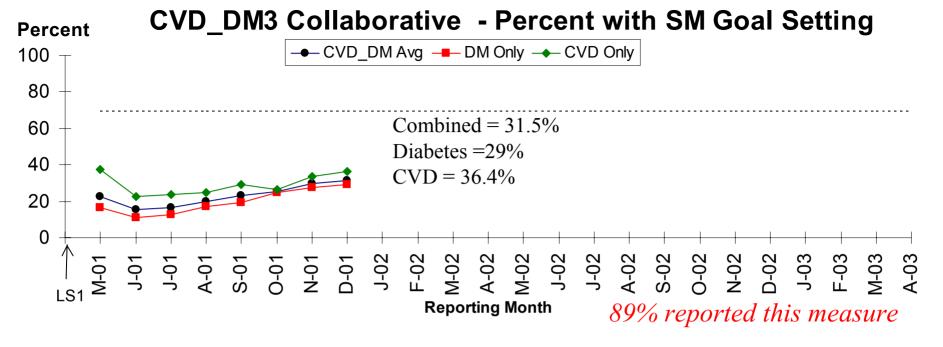


### Diabetes Collaborative 3 - National Report Average HbA1c's

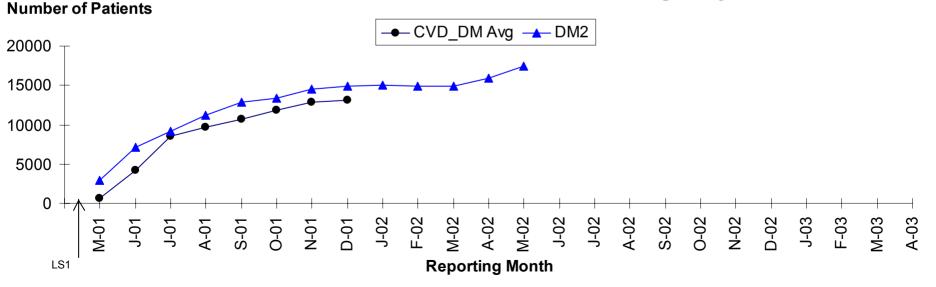


### Phase 2: Average HbA1c's

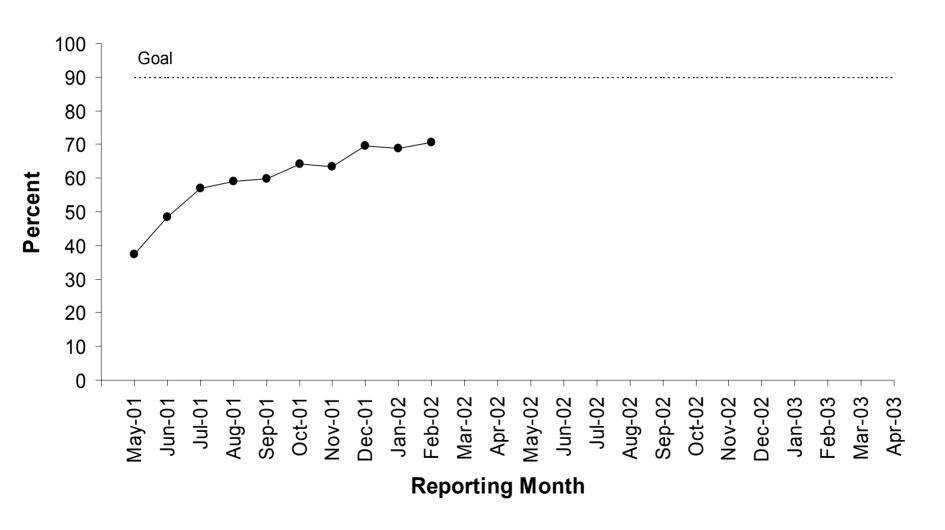




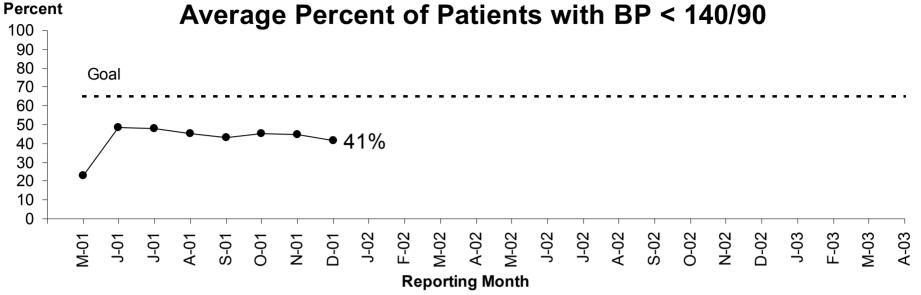
#### CVD\_DM3 Collaborative - Total Registry Size

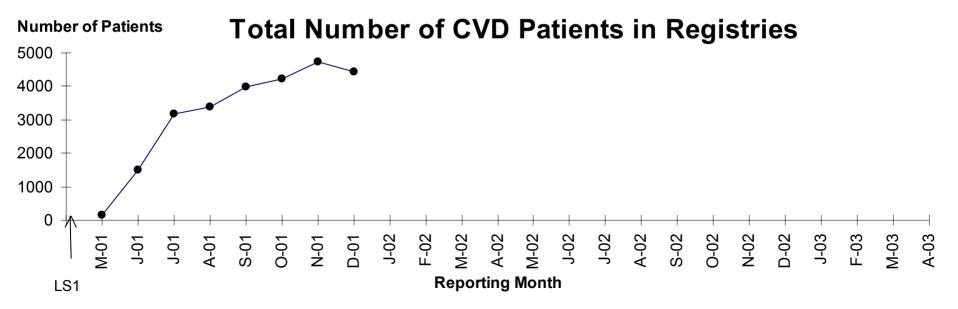


#### CVD Collaborative 1 - National Report Average Percent of Patients with Two BP's in Last 12 Months









## Partnership Outcomes

- CDC lead for expert panel for both diabetes & cardiovascular disease collaboratives
- 60 Health Center Diabetes Control partnerships
  - 22 new
  - 38 expanded
- Trained over 40 state Diabetes Control Programs
- Collaboration with American Diabetes Association, Bayer Corp.

#### Prevention & Chronic Disease Management

## **Beyond Diabetes: Collaboration to Improve Health & Access**

- Current:
  - •DM/Cardiovascular: CDC/SAMSHA, IHI
  - •Asthma II: EPA/CDC, IHI
  - •HIV: HIV/AIDS Bureau
  - •Depression II: SAMHSA, IHI
- •In Development:
  - •Cancer: NIH(NCI), ICIC, CDC, IHI
  - •Prevention: NCI, CDC, MCHB, IHI

## Diabetes Prevention Pilot: CDC & HRSA Partnership

- Develop concepts and measures for translating recommendations into primary care for the underserved, using care model
- Incorporate in both diabetes collaborative and future prevention collaborative
- Time frame: begin pilot 3<sup>rd</sup> quarter 02 and continue for 9-12 months as part of development of prevention collaborative